STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295081	A. BUILDING _____ B. WING _____	C 12/15/2008

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NEVADA STATE VETERANS HOME - BOULDER CITY	100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation at your facility on December 15, 2008. The following complaint was investigated: CPT # NV00020237 - Substantiated with deficiencies (see Tag F157) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiency was identified at the time of the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		2/11/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, documentation review and closed record review, the facility failed to ensure the Resident's (#1) attending physician was notified following two external consultations, conducted by two separate Dentists. Findings include: Resident #1 Resident #1 was a 74 year-old female resident originally admitted on 7/8/08 and readmitted on 12/2/08, with diagnoses including Congestive Heart Failure, Parkinson's Disease, Alzheimer's Disease, Dementia, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Hypertension, Esophageal Reflux Disease, Seizure Disorder, Debility, Pneumonia, Urinary Tract Infection, Sepsis, and Methicillin-Resistant Staphylococcus Aureus. Interview: During an interview on 12/15/08 at 11:10 AM, the	F 157		

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Director of Nursing (DON) indicated Resident #1 returned from her dental appointment on 11/18/08, following the extraction of several teeth. The DON indicated the resident looked fine, other than some visual bruising to the lower outer jaw.

The DON continued by indicating within a couple days following the dental appointment and in the early morning, the resident began to spike a high temperature, blood pressure lowered, and became less responsive. She indicated the resident was quickly transferred to Boulder City Hospital for evaluation and treatment on 11/20/08.

The DON further indicated in the interview that the resident remained at Boulder City Hospital for approximately a week, receiving antibiotics and treatment for signs of early Sepsis. During the stay she indicated the resident began a decline in health and upon the resident's return, she mentioned the resident was admitted with intravenous antibiotics and on a high rate of oxygen. She mentioned that the resident's physician was confident that Resident #1 would not last very long. She indicated that the physician talked with the resident's spouse and other family members about the facility's end of life program.

On 11/15/08 at 11:25 AM, the Performance Improvement/Staff Educator indicated Resident #1 had seven teeth extracted on 11/18/08. She indicated on 11/20/08 at 3:15 AM, the resident was sent out to Boulder City Hospital for evaluation and treatment for a change of condition.

The Performance Improvement/Staff Educator

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further indicated the resident returned on 12/2/08, and expired on 12/3/08. She indicated upon the resident's readmission, the doctor removed the medication orders and initiated comfort only orders following the family's request for the resident to return to the facility.

The Performance Improvement/Staff Educator indicated that Resident #1 first saw Dentist A, but since the resident was on Medicaid, they scheduled the next appointment with Dentist B. She indicated that Resident #1 did attend her initial appointment with Dentist B on 9/30/08, which he recommended teeth extractions and future denture fittings.

The Performance Improvement/Staff Educator further indicated in the interview that upon return to the facility, the nurse did not contact Resident #1's physician or his office concerning the appointment. She acknowledged that the staff should have made the resident's physician aware of the results of the consultation and should have placed Dentist B's recommendation document in Resident #1's physician's mail box for review.

She also indicated that she was aware Dentist B documented the examination showed infection and there was a need to extract the teeth. She also indicated there was no order for antibiotic therapy by Dentist B and in her investigation, dentists for the most part will not initiate prophylaxis due to the over use of antibiotics.

Side Note: On 12/15/08 at 12:30 PM, the DON indicated that the facility held an in-service on 12/11/08 for Nurse Managers concerning procedures to follow after residents return from having external consultations and what to do

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F 157	Continued From page 4 when there are orders or recommendations from the consultants. She indicated that the facility's current policy contained a process in which new orders from the consulting physician or other professionals would be confirmed by the resident's physician and written onto the physician's order form as a verbal order. Documentation review: The facility's policy and procedure titled "Consultation/Clinic Referral" for external consultations, dated 5/28/02, indicated the resident leaves with several documents including the facility's Consultation Referral form. It was indicated in the policy that the consulting physician or allied health professional was to complete the lower half of the form with any new orders and return the form with the resident back to the facility. It was indicated in the policy, once the resident has returned to the facility, staff would get any new orders confirmed with the attending physician and transcribe the order to the Physician's Order form as a telephone/verbal order. The policy indicated the orders must be written onto the resident's chart under the attending physicians name. A letter and Root Cause Analysis report was submitted to the Veterans Southern Nevada Healthcare System and the Bureau of Licensure and Certification (BLC) on 12/9/08. It documented through their investigation and analysis that the Registered Nurse (RN) did not follow policy and notify the attending physician following the Consultation with Dentist B on 9/30/08.	F 157		

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Resident closed record review:
A nursing entry in the Interdisciplinary Progress Notes on 9/15/08 at 1000 (10:00 AM), indicated Resident #1 had a dental consult scheduled with Dentist A on 9/16/08 at 1230 (12:30 PM).

The facility's Consultation/Referral form, dated 9/16/08, indicated the resident was to have a dental consultation as requested by the resident and resident's husband. It was noted under the form's "Consultant/Clinic Use" section that the resident had "decay on #20 - unrestorable." Dentist A noted on the form that he extracted the tooth. There was no evidence of infection, complications or new orders documented on the form.

A nursing entry in the Interdisciplinary Progress Notes on 9/30/08 at 1200 (12:00 PM), indicated Resident #1 was out of the facility for a dental appointment. It was indicated in the note that the resident was served an early lunch and received mouth care prior to leaving for the appointment.

The facility's Consultation/Referral form, dated 9/30/08, indicated the resident was to have a dental examination (exam) for possible dentures and extraction as requested by the husband. It was noted under the form's "other comments" section that "we did exam/exam showed infection and we need to remove teeth and do dentures." There was no documented evidence of new diagnosis, recommendations and orders indicated by Dentist B.

There was no documented evidence in the progress notes that indicated the resident's return

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to the facility following the external consultation with Dentist B. Further review, revealed no documented evidence the resident's attending physician was contacted and communicated the findings of the consultation.

Review of physician orders from 7/14/08 through 11/20/08, revealed no documented evidence which indicated the resident required antibiotic therapy for symptomology of infection.

Review of the facility's Vital Signs Record for Resident #1 from 7/22/08 through 0030 (12:30 AM) on 11/20/08, indicated no evidence the resident ever experienced elevated body temperature during her stay at the facility.

The review of the resident's progress notes from 9/6/08 through 11/18/08, prior to her teeth extraction by Dentist A and Dentist B, indicated no documented evidence the resident complained of mouth pain or other issues possibly related to the symptomology of infection.

Review of the resident's Medication Administration Record (MAR), indicated physician orders for Tylenol 325 mg (milligrams) orally every 4 hours as needed or Tylenol 10 grams rectal suppository every 4 hours as needed for temperatures exceeding 101 degrees.

The resident's MAR indicated no documented evidence the resident was administered any form of Tylenol during September and October 2008. The first documented use of Tylenol for elevated temperature was on November 20, 2008 at 0110 (1:10 AM). The first use of Tylenol (Tylenol 650 mg orally) for pain was on 11/18/08, following extraction of 7 teeth.

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F 157	Continued From page 7 Further review of the MAR revealed no physician orders for antibiotic therapy during the months of September, October and November 2008. The first documented evidence of an order for antibiotic therapy (Vancomycin 1,250 mg intravenously (IV) central line every 12 hours for 7 days and Rocephin 1 gram IV central line daily for 7 days) was on the resident's readmission orders to the facility on 12/2/08. The third Consultation/Referral form, dated 11/18/08, indicated the resident was scheduled for her preparation for dentures and pulling the remaining teeth with Dentist B. It was noted under the form's "other comments" section that "we removed 7 teeth on lower she has 6 sutures we will remove at denture appointment." There was no documentation on the resident's Consultation/Referral form dated on 11/18/08, which indicated Resident #1 had an infection or other complications related to the visit with Dentist B. Review of the facility's Interdisciplinary Progress Notes on 11/18/08 and 11/19/08, revealed significant documentation through the day, which indicated the staff had assessed and delivered care to the resident following the extractions. On 11/19/08 at 1630 (4:30 PM), revealed an entry which indicated the facility received a telephone call from Dentist B. It was indicated in the note that facility staff informed Dentist B of the bruising to the chin and lower jaw, which he indicated was expected. No mention of other complications were documented in this entry.	F 157		

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F 157	Continued From page 8 All three dental consults for Resident #1 had forms sent with the resident and returned to the facility following the appointments. Each form had evidence of facility staff signatures with corresponding dates on lower half of each form, which indicated the facility received treatment information following each dental visit. However, there was no documented evidence of physician notification following the visits with Dentist A on 9/16/08, and with Dentist B on 9/30/08.	F 157		